
# Medicaid Management Information Systems

## *Maine Integrated Health Management Solution*
## *Health PAS Online: Professional Claim Submission and Claim Status User Guide*

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# HIPAA Notice

This Maine Health PAS Online Portal is for the use of authorized users only. Users of the Maine Health PAS Online Portal may have access to protected and personally identifiable health data. As such, the Maine Health PAS Online Portal and its data are subject to the privacy and security regulations within the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (HIPAA).

By accessing the Maine Health PAS Online Portal, all users agree to protect the privacy and security of the data contained within as required by law. Access to information on this site is only allowed for necessary business reasons, and is restricted to those persons with a valid user name and password.

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# 1. Introduction

Using the Maine Integrated Health Management Solution (MIHMS) Health PAS Online Portal (online portal), MaineCare providers can quickly and easily enter professional, institutional, and dental claims. This guide will walk the user through the process of entering a professional claim and modifying it as necessary.

***HINT:*** *If the user is not already a registered Trading Partner, click the link to the Trading Partner User Guides for more information*

# 2. Information Needed

Before beginning the claims submission process, it will be useful to have the following information, forms, and other documents on hand:

- Verify that the recipient is eligible on the date of service for the services rendered.
- Medicaid is always the payer of last resort. If the member has Medicare or third party insurance, bill them first before billing Medicaid.
- Gather complete member, provider and service information associated with the claim.

# 3. System Requirements

To successfully use all features of the online portal, ensure that computer systems meet the following minimum requirements:

- Reliable online connection
- Web browser - The latest version of Microsoft Internet Explorer is recommended. As new versions of Internet Explorer become available it is recommended that these versions are used.
- The latest version of Adobe Acrobat Reader

# 4. Form Entry: Claim Submission

To begin a claim submission, click the **Claim Submission** link located below the Form Entry heading on the portal links, as shown in Figure 4-1 below. Now the Submit Claim – Find Member screen will display.

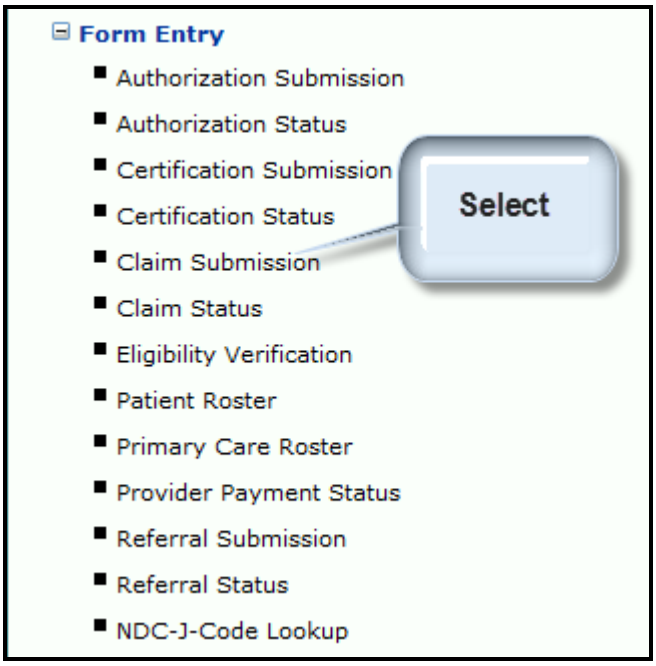


**Figure 4-1: Claim Submission**

The **Submit Claim** button is also available directly from the Eligibility Verification, Patient Roster, and Primary Care Roster screens.

The Submit Claim function uses a wizard to guide the user through the steps of the process. The wizard starts with Find Member, as shown in Figure 4-2 below.

## 4.1 Step 1– Find Member

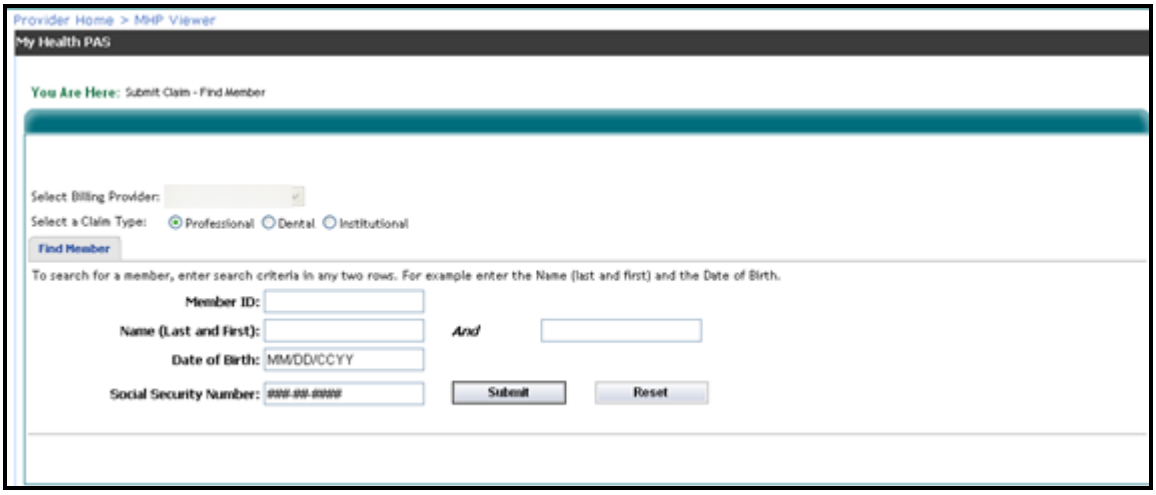


**Figure 4-2: Find Member**

Use the instructions below to execute a member search associated with a claim submission. Figure 4-2 above shows the Find Member Search Fields.

1. If there is more than one **Billing Provider** associated with the Trading Partner ID, click the drop-down menu to select the proper Billing Provider from the pre-determined list. Figure 4-3 below, shows an example of a Billing Provider drop-down menu.


**Figure 4-3: Select Billing Provider**

2. Select the proper claim type by clicking the radio button next to the "Professional" option.
3. Enter member search criteria. Two of the four available search criteria fields must be filled for a successful member search:
    - Member ID
    - Name (Last and First)
    - Date of Birth
    - Social Security Number

**Additional details on entering search criteria for the member search**:

- The **Last Name** and **First Name** count as one search criterion.
    - On the search screen, enter the Last Name in the first field and the First Name in the second field- see Figure 4-2 above.
    - Names must match exactly for the first five letters of the last name and the first three letters of the first name.

***HINT:*** *If no match is found, try fewer criterions. For example: Jane Example-Member could be entered as Examp for the last name and Jan as the first name. Alternatively, do not use the name criteria, but MaineCare ID and Date of Birth.*

- The **Date of Birth** must be entered in the MM/DD/CCYY format.
    - For example, February 14, 2008 would be entered as "02/14/2008".
- The **Social Security Number** should be entered without any dashes.

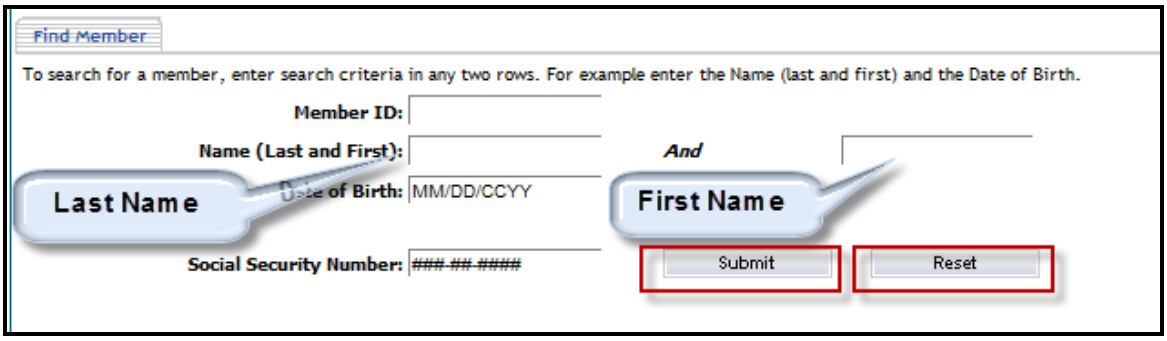


**Figure 4-4: Member Search**

- Select the **Submit** button to perform a search.
    a. To start the search over, select the **Reset** button to clear all the values entered in the Find Member search fields- see Figure 4-4 above.
- The search results are returned under the Find Member Results tab, as depicted in Figure 4-5 below. The results will include a list of all the members that meet the search criteria. It will display their Name, Gender, and Date of Birth.

    a. **If the search returns multiple results**, select the correct member by clicking the checkbox in front of that member's name as shown in Figure 4-5 below. Click the **Continue** button.

b. **If the member is not returned in the search**, click the **Cancel** button to reset and clear all the values entered in the find member search. See the hint under Step 3.

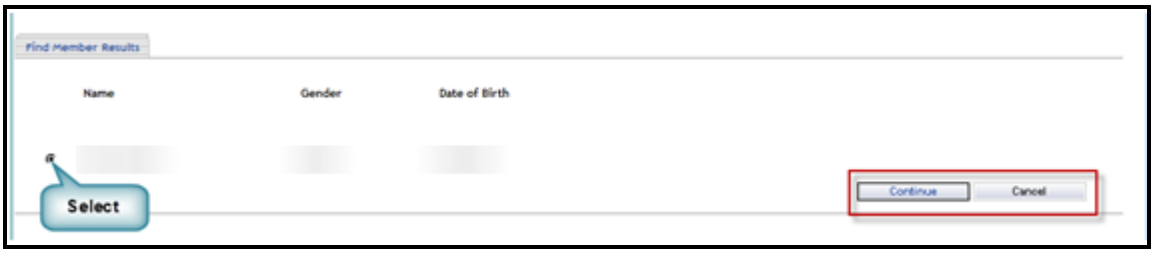


**Figure 4-5: Member Search Results**

## 4.2 Step 2 – Professional Claim Submission

Upon the selection of the member for a professional claims submission, the Claim Wizard – Professional Claim screen (CMS 1500) will populate. There are four sections associated with this screen as shown in Figure 4-6 below: **Claim Information**, **Diagnosis**, **Services**, and **Additional Information**.

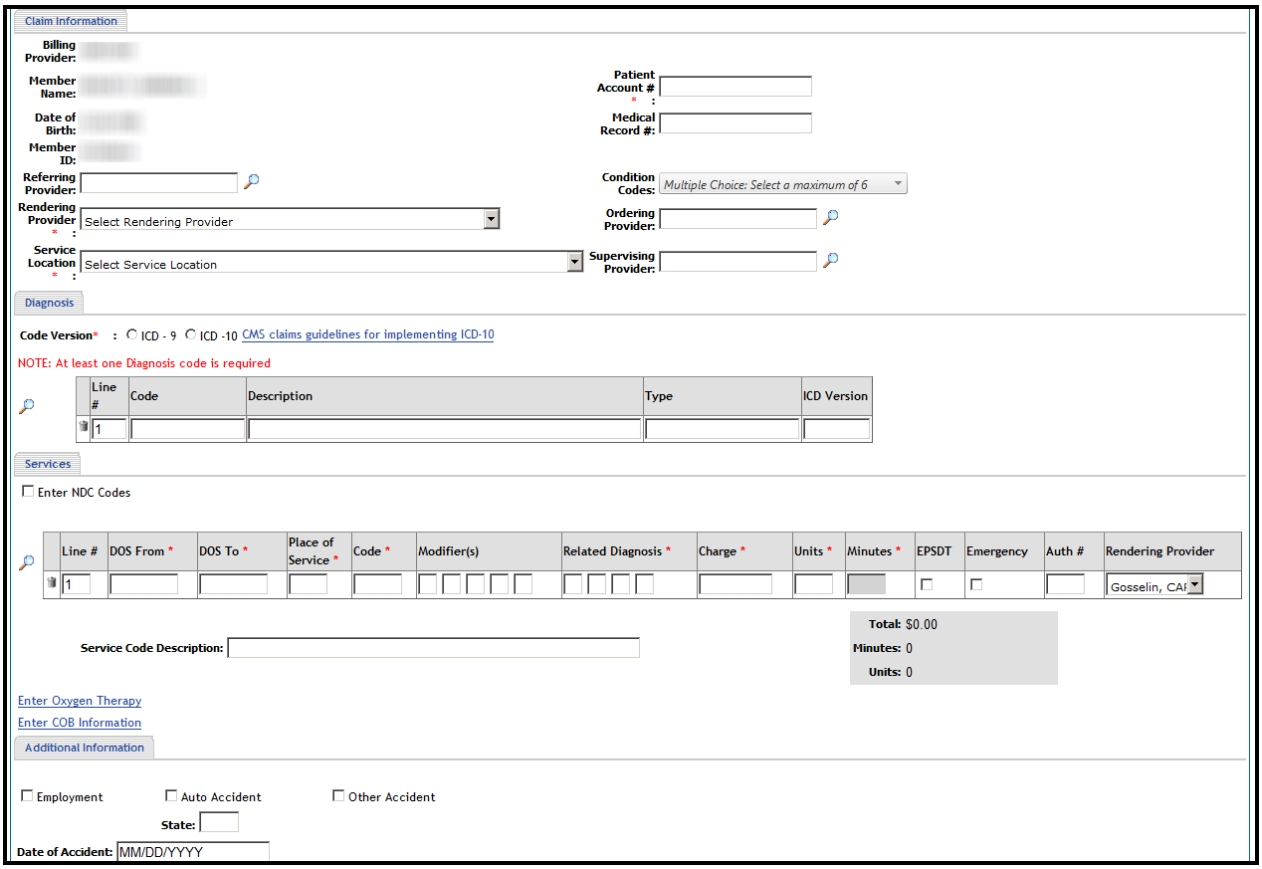


**Figure 4-6: Professional Claim**

Input fields with a red asterisk (*) are required. An error message will be displayed if these values are left blank.

***NOTE:*** *Always tab through fields on a single line (such as in the Services Section) to ensure proper completion.*

Some claim items, like diagnosis codes, may have additional lines added. To add more lines, tab through the last line. In order to delete a line, select the option button  in front of the line.

Proceed through the sections below to complete this screen:

### 4.2.1 Complete the Claim Information Section

The Claim Information section is shown in Figure 4-7 below.

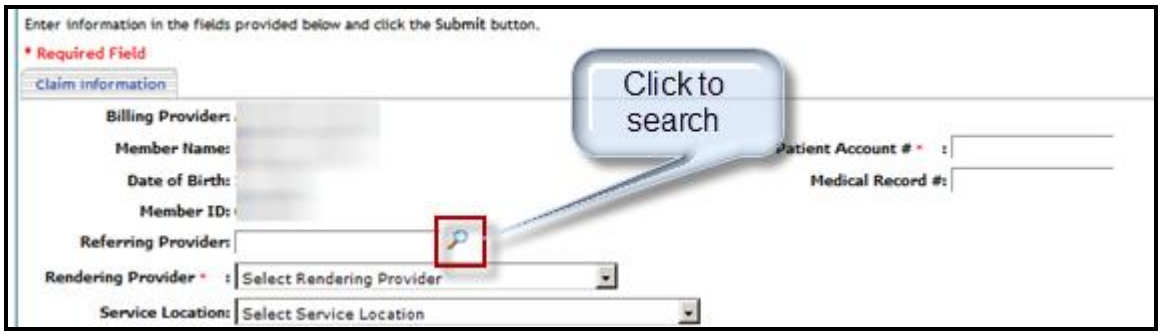


**Figure 4-7: Claim Information**

Use the tips below to complete this section:

Table 1below supplies descriptions and instructions for each field shown in Figure 4-7 above. Use it to complete this section:

**Table 1: Claim Information**

| Field Name | Field Description |
|---|---|
| **Referring Provider** | This field is required.<br><br>Enter the referring physician by using the look up function. For additional instructions on how to use the provider look up function go to Section 4.2.1.1: Provider Look Up Function. |
| **Rendering Provider** | This field is required.<br><br>Enter the rendering provider by selecting the drop-down arrow and clicking on the appropriate option.<br><br>The drop-down selection for this field will show a list of providers if there is more than one rendering provider option. |
| **Service Location** | This field is required if the provider is enrolled with more than one service location.<br><br>Enter the billing provider service location by selecting the drop-down arrow and clicking on the appropriate option.<br><br>The drop-down selection for this field will show a list of locations if the provider has more than one service location. |

| Field Name | Field Description |
|---|---|
| **Patient Account #** | This field is required.<br>The alpha numeric information assigned by the provider that is returned on any Remittance Advice (RA). |
| **Medical Record #** | The alpha numeric information assigned by the provider. |

### 4.2.1.1 Provider Look Up Function

To access the provider look up function, click on the icon next to a provider information field. The **Provider Search** screen will populate with provider search criteria as depicted in Figure 4-8 below.

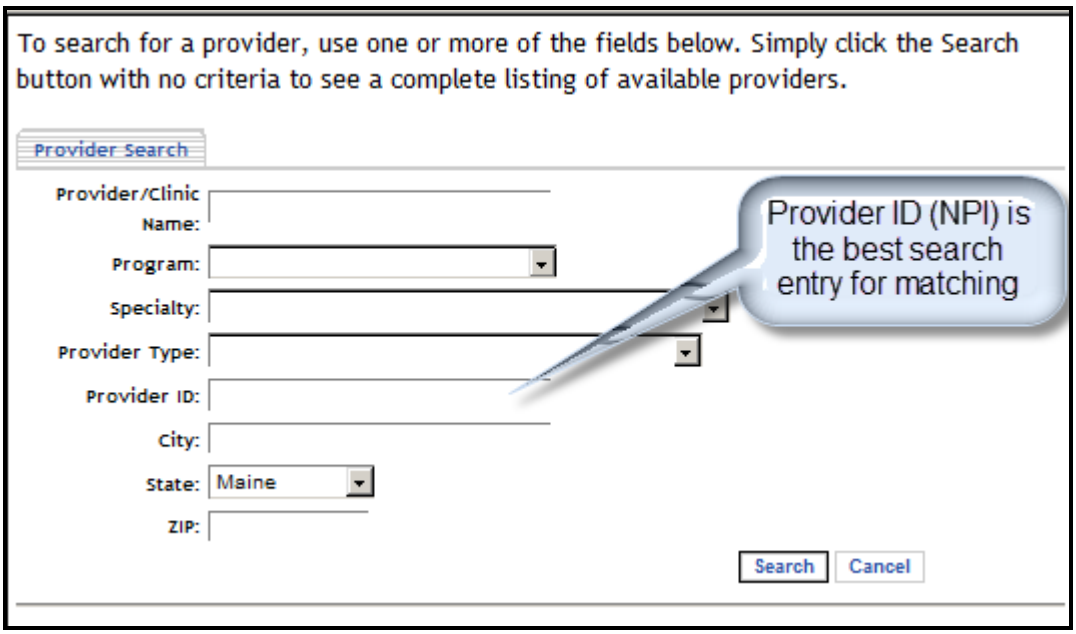


**Figure 4-8: Provider Search**

***NOTE:*** *To search for a provider, use one or more of the fields or click the search button with no criteria to see a complete listing of available providers.*

1. Enter the search criteria.
   a. Drop-down boxes are used to select values for **Specialty**, **Provider Type**, **Program**, and **State**.
   b. Some lists may have a blank line to allow searching all data.
   c. All other fields must match exactly for this search function.
   d. Click **Cancel** to cancel the search and go back to the Professional Claim Wizard, as referenced in Section 4.2: Step 2 – Professional Claim Submission.
2. Click the **Search** button. The results will be listed at the bottom of the **Provider Search** page, under **Search Results**.
3. The results will display the provider's name, provider ID, address, phone number, specialty, and provider type, as depicted in Figure 4-9 below.
4. Select the radio button next to the **Provider Name** and click **continue** to return to the **Claim Information** page.


**Figure 4-9: Provider Search Results**

## 4.2.2 Complete the Diagnosis Section

Complete the Diagnosis section as depicted in Figure 4-10 below. The diagnosis section is used to enter the diagnoses associated with the services provided to the member.

**NOTE**: Effective on 10/1/2015, providers will be able to enter both ICD-9 and ICD-10 based claims. The following changes to the portal will be available:

- ICD-9 and ICD-10 radio buttons will be provided in diagnosis code session. Selection of one radio button will be required to differentiate between ICD-9 and ICD-10 based claims. A diagnosis code cannot be entered before one of the ICD radio buttons is selected. After a diagnosis code is entered, the ICD radio button selection cannot be changed.
- A link called 'CMS Claims Guidelines for Implementing ICD-10' will be available to the right of the ICD radio button selection if additional ICD-10 information is needed.

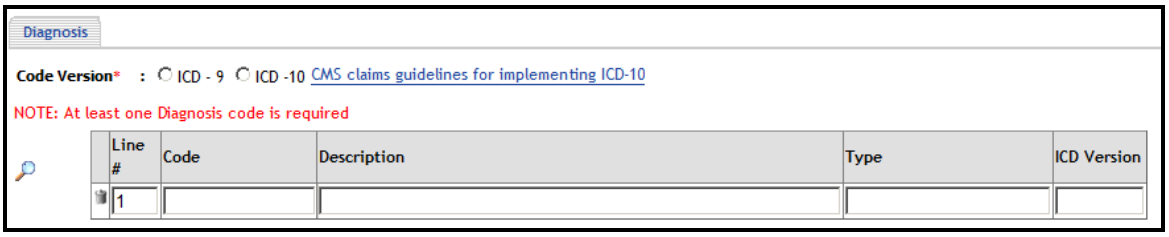


**Figure 4-10: Professional Diagnosis Section**

Use the bulleted tips below to complete this section:

- There are four fields in the Diagnosis section: **Line #**, **Code**, **Description**, and **Type**. The only editable field is **Code** (see note above about the ICD code selection).
- To add a new line, hit tab at the end of the last line and a new line will appear. The **Line #** will increase as each line is added. Up to 12 diagnosis codes may be submitted.
- To make the **Description** and **Type** appear, enter the code in the first field and hit tab to proceed to the next two fields.
- The first line entered will be the primary diagnosis and all additional lines will be considered secondary.

***NOTE**: For most claims, services prior to and on or after 10/01/2015 need to be billed on separate claims. For claims with dates of service of 10/01/2015 and forward, use the appropriate ICD-10-CM code. For claims with dates of service prior to 10/01/2015, use the appropriate ICD-9-CM code, with the following exceptions:*

- *Claims with services prior to and on or after 10/01/2015 can be billed on the same claim form if the claim is a DMEPOS claim. If the DMEPOS claim has a from date prior to 10/01/2015 and a*

*through date on or after 10/01/2015, the entire claim is billed using ICD-9-CM codes based on the from date of service.*

- *Claims with anesthesia procedures that begin on 09/30/2015, but end on 10/01/2015, are to be billed with ICD-9 diagnosis codes and use 09/30/2015 as both the FROM and THROUGH date.*

### 4.2.2.1 Diagnosis Search Function

To access the **Diagnosis Codes** search function, click on the icon next to the **Line #** and a new search window will open-see Figure 4-11 below.

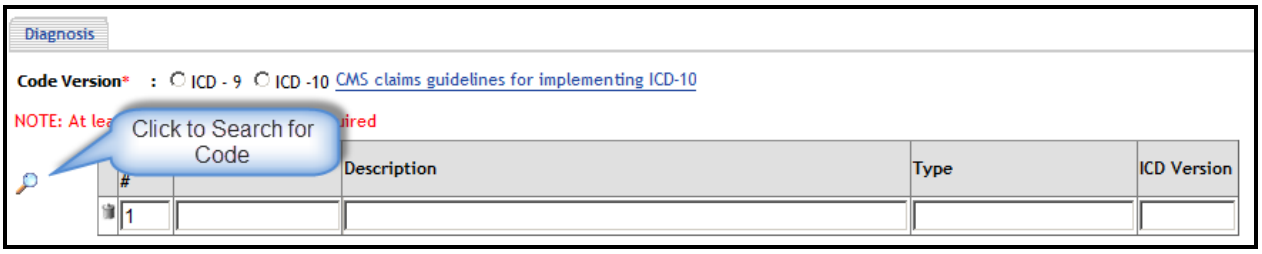


**Figure 4-11: Diagnosis Code Search**

1. Enter any part of the description of the code in the **Description** field.

***HINT:*** *MIHMS will match exactly the sequence of characters entered in the search criteria. For example: if no match is found for "Sleep Disorder" try just "sleep". Conversely, using just the word "disorder" may be too broad and result in a longer list.*

2. Click the **Search** button to retrieve a list of results. The system will look for the text entered regardless of where it falls in the description.
    a. To start over, click the **Reset** button to clear the **Description** field.
3. The diagnosis search will return a list of **Code ID**s, **Descriptions, Effective** and **Term dates,** and **ICD Versions**, as shown in Figure 4-12 below. Click any **Code ID** link to populate the Code ID to the **Diagnosis** section.

    **NOTE**: Effective on 10/01/2015, the Code ID displayed in the search field will be based on the ICD-radio button selection made as part of the steps listed in section 4.2.2. For example, if a user chose the ICD-10 radio button, only ICD-10 codes will display in the Code ID field.
4. Once the Code ID is displayed, tab through to populate the description and type. A new line will be presented if additional codes need to be entered.
    a. Additional blank lines will not affect the processing of the claim.

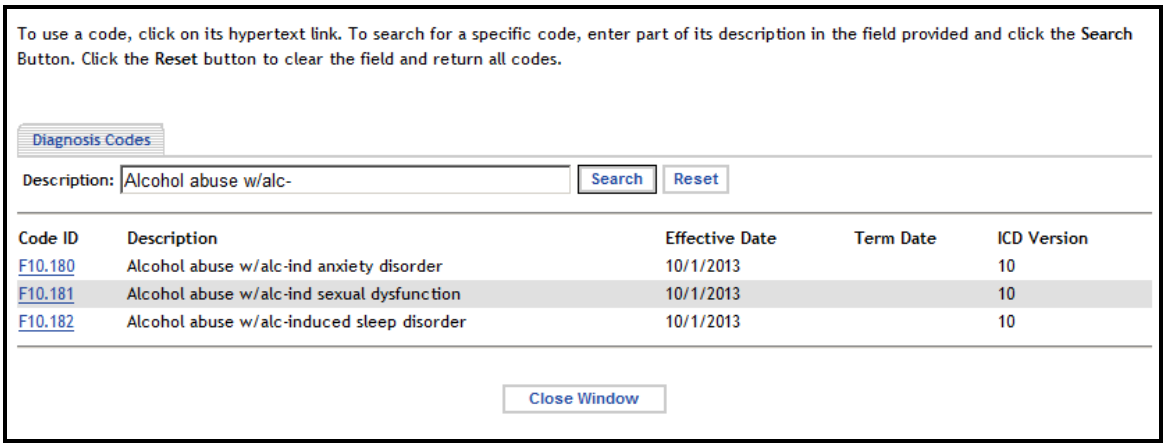


**Figure 4-12: Diagnosis Code Search Results**

***NOTE:*** *Ambulance claims must include a diagnosis code. For dates of service prior to 10/01/2015, use ICD-9 code 780.99 (Other General Symptoms). For Dates of Service of 10/01/2015 and forward, use the appropriate ICD-10 code: R45.84 (anhedonia) or R68.89 (other general symptoms and signs).*

### 4.2.3 Complete the Services Section

Complete the Services Section as depicted in Figure 4-13 below.

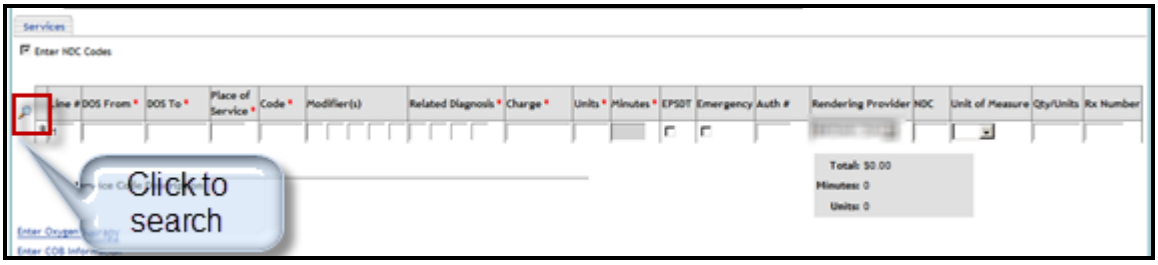


**Figure 4-13: Professional Services Section**

This section of the claims screen is used to enter the Services rendered to the member that will be included in the claim submission. The fields and links associated with this section are summarized in Table 2 below.

***NOTE:*** *Additional information on covered services can be found in the MaineCare Benefits Manual.*

*If a member has a coverage code of "Spenddown", the spenddown letter must be obtained and attached to the claim. Please see Section 4.3.4: Upload Attachments for more information. Spenddown claims are entered via Direct Data Entry (DDE) according to the usual professional claim entry instructions in this guide in Section 4: Form Entry: Claim Submission.*

**Table 2: Claim Service Section**

| Field Name | Field Description |
|---|---|
| **Enter NDC Codes** | Select the **Enter NDC Codes** check box to enter a service line for physician administered drugs. This action will make the following fields on the service line editable:<br>• **NDC**<br>• **Unit of Measure**<br>• **Qty/Units**<br>• **Rx Number**<br>The MIHMS Health PAS Online Portal allows providers to query procedure code/NDC combinations and NDC rebate information by specific dates. The portal will then display valid J-Codes and NDC combinations for MaineCare. More information about this functionality is included as Appendix C to this document. |
|  | Click this icon to delete a service line. |
| **Line #** | This is a system-generated field used to number each service line added by the user.<br>To add a new service line, hit tab at the end of the last line and a new line will appear. |
| **DOS From/DOS To** | This field is required.<br>Enter the beginning and ending dates of the period in which the service was provided.<br>Dates must be entered in MM/DD/CCYY format. For example, February 14, 2008 would be entered as “02/14/2008”. |
| **Place of Service** | This field is required.<br>Enter the appropriate two-digit place of service code(s).<br>Use a place of service code to identify the location for each item used or service performed.<br>**Durable Medical Equipment and Supplies Providers**: Use the Place of Service code where the member resides.<br>See Appendix A for a full code list. |
| **Code** | This field is required.<br>This field represents the CPT code for the service. Enter the code in this field if known or use the  link to perform a code search. The search link is located in front of the Service Line as shown in Figure 4-13. |

| Field Name | Field Description |
|---|---|
| **Modifier(s)** | CPT code modifiers provide additional details regarding various services.<br><br>CRNAs bill with the QZ modifier for a CRNA service without medical direction by a physician and a QX for CRNA service with the medical direction by a physician.<br><br>Repair/Replacement Procedures must be billed with the RA or RB modifiers as appropriate.<br><br>Bi-lateral procedures require the code with the 50 modifier on one claim line. (Procedure is reimbursed at 150% of the allowed amount.)<br><br>Family Planning services must be billed using "FP" modifier. Family Planning services are those provided to prevent or delay pregnancy or to otherwise control family size. Counseling services, laboratory tests, medical procedures and pharmaceutical supplies and devices are covered if provided for family planning purposes.<br><br>State Supplied Vaccines require the use of the "SL" modifier on both the administration code and the vaccine code.<br><br>Ambulance providers should insert the H9 modifier before the origin/destination code, when appropriate. In the Modifier Box, enter the appropriate two letters for the transport's place of origin and destination. See Appendix B for a list of these codes and their definitions. |
| **Related Diagnosis** | This field is required.<br><br>The Related Diagnosis field corresponds with the line number or numbers in the Diagnosis section above that support(s) the service line. Up to 12 diagnosis codes are allowed; therefore, double digit entries are allowed in the related diagnosis section. |
| **Charge** | This field is required.<br><br>Enter the total dollar amount charged for the services.<br><br>The system will add the dollar sign ($) and will assume two decimal places unless specifically entered by the user. |

| Field Name | Field Description |
|---|---|
| **Units** | This field is required.<br><br>Enter the number of times the service being billed was performed.<br><br>***NOTE**: For anesthesia claims, the units will default to one (1). The code range is 00100 – 01999. For anesthesia services, the provider must enter the number of anesthesia minutes in the Minutes field.*<br><br>Units must be whole numbers.<br><br>Do not use decimal points or fractions (e.g. 1.5 or 1/2)<br><br>In cases where services provided include less than a whole unit of service, the unit shall be rounded up only if equal to or greater than fifty percent (50%) of the unit of service (e.g. 1.5 units of service equals 2 units of service rounded up; 1.4 units of service equal 1 unit of service). The procedure code for the smallest unit of service must be used.<br><br>Specific provisions in any other Chapters or Sections of this manual, or in the CMS 1500 Billing Instructions Guide, will supersede this rounding requirement.<br><br>The CMS 1500 Billing Instructions Guide may be found at the following link:<br><br>https://mainecare.maine.gov/Billing%20Instructions/Forms/Publication.aspx |
| **Minutes** | This field is required for anesthesia services.<br><br>Enter the number of anesthesia minutes for the service being billed.<br><br>***NOTE**: For anesthesia claims, the units will default to one (1). The code range is 00100– 01999. The Minutes field will appear greyed out until an anesthesia code is entered.* |
| **Early Periodic Screening Diagnosis Treatment (EPSDT)** | If the service the user is billing for is associated with EPSDT enter “Y” in this field.<br><br>This field defaults to “N”. |
| **Emergency** | For services delivered during an emergency situation that typically require Prior Authorization, a “Y” must be entered in this box.<br><br>An appropriately entered “Y” submitted in this field will prevent a copay from being deducted for services subject to a copay.<br><br>***NOTE**: Refer to Chapter I of the MaineCare Benefits Manual for a list of services exempt from copays:*<br><br>http://www.maine.gov/sos/cec/rules/10/ch101.htm |
| **Auth #** | Required for services where multiple Prior Authorizations (PAs) exist for the same date, service, member and provider. Enter the PA number issued by the authorizing unit for the services or supplies being billed. Bill only one PA number on each claim. A PA number entered must exactly match the authorization number in MIHMS including both alpha and numeric characters. |

| Field Name | Field Description |
|---|---|
| **Rendering Provider** | This field captures the provider that rendered the service for which the claim is being submitted.<br><br>Select by clicking on the drop-down arrow and choosing the appropriate provider.<br><br>Providers billing for interpreter services need to put the healthcare provider's rendering ID on the claim.<br><br>A claim form may only have one (1) rendering NPI. The same rendering provider could bill multiple services on a single claim. |
| **National Drug Code (NDC)** | The National Drug Code (NDC) is the number which identifies a drug. The NDC number consists of 11 digits. |
| **Unit of Measure** | Enter the NDC unit of measurement. The unit of measurement codes are:<br>• F2- International Unit<br>• GR– Gram<br>• ME- Milligram<br>• ML- Milliliter<br>• UN- Unit |
| **Qty/Units** | NDC units are based upon the numeric quantity administered to the patient and the unit of measurement.<br><br>Enter the actual metric decimal quantity administered in this field. |
| **Rx Number** | The Rx Number field should be used when the dispensing of the drug was done with a prescription number or when the dispensed drug involves the compounding of two or more drugs and there is no prescription number.<br><br>If there is no prescription number, a "link sequence number" is reported, which is a provider-assigned number that is unique for the claim. The link sequence number matches the components, similar to the prescription number. |
| **Service Code Description** | This field will automatically populate.<br><br>Description of the service code entered for the specified service line. |
| **Total** | This field will automatically populate.<br><br>This field displays the total dollar for all service lines entered. |
| **Minutes** | This field will automatically populate.<br><br>This field displays the total number of minutes for all service lines entered. |
| **Units** | This field will automatically populate.<br><br>This field provides a sum of the number of service units billed at the service line level that is automatically calculated. |

***NOTE***: *When a service code is entered, the description will appear in the* ***Service Code Description*** *box. The Total Price and Total Units will be totaled in the grey area next to the* ***Service Code Description*** *field; as shown in Figure 4-13 above.*

### 4.2.3.1 CPT Search Function

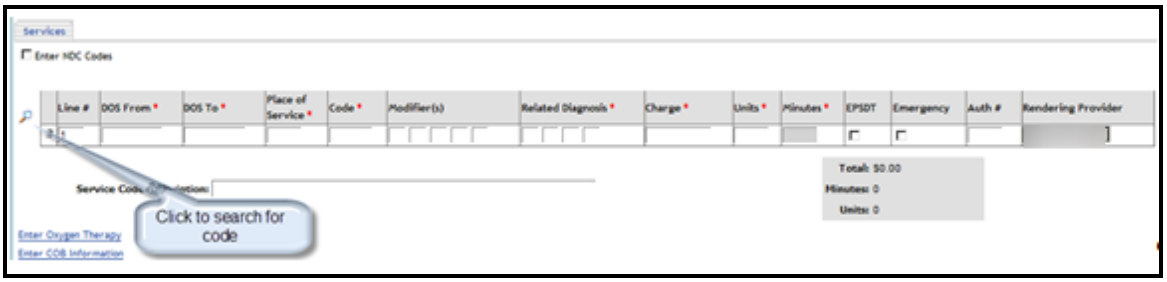


**Figure 4-14: CPT Search Function Icon**

To search for a **Service Code,** click the button next to the **Line**, as shown in Figure 4-14 above and a new search window will open. See Figure 4-15 below.


**Figure 4-15: CPT Search Function**

1. Enter any part of the description of the code in the **Description** field.

***HINT:*** *MIHMS will match exactly the sequence of characters entered in the search criteria. For example: if nothing is found for "sinus surgery" try just "sinus". Conversely, using the word "surgery" may be too broad and result in a longer list.*

2. Click the **Search** button to retrieve a list of results. The system will look for the entry regardless of where it falls in the description.
    a. To start over, click the **Reset** button to clear the **Description** field.

3. The search will return a list of **Service Codes**, their **Description**, and **Effective** and **Term Date**. Single-click any **Service ID Code** link to return it to the **Code** field; as shown in Figure 4-16 below.

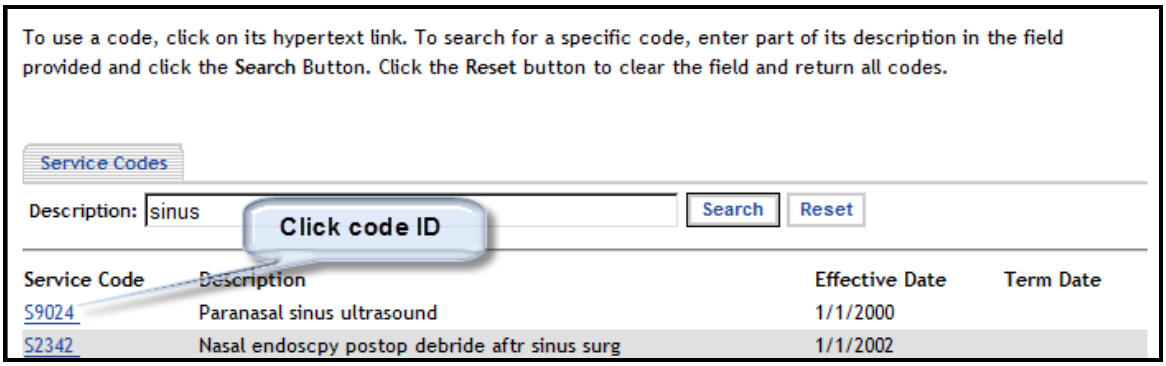


**Figure 4-16: CPT Search Function Results**

## 4.2.4 Enter COB Information

The user may enter the information for Coordination of Benefits (COB) by selecting the **Enter COB Information** link below the Service Code area.

- The COB information may be entered either by Claim or by Service Line for any external totals to be applied as COB. Information must be entered at the Service Line level when available on the Explanation of Benefits (EOB). When possible, enter detail at the Line Level for more accurate claims processing, as shown in Figure 4-17 below.

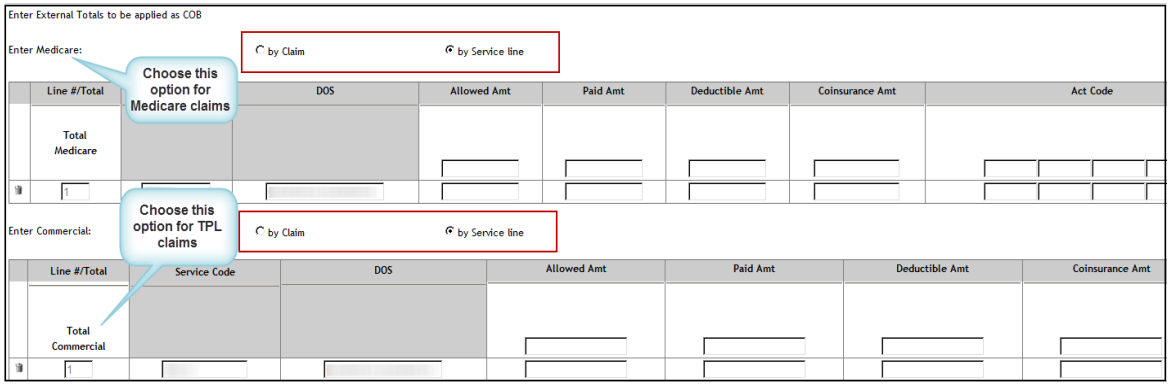


**Figure 4-17: COB Information**

- Choose the Medicare or Commercial option as appropriate- see Figure 4-17 above.
  - If entering claims when Medicare C is primary, choose the Medicare option.
  - If entering claims for Third Party Liability (TPL), choose the Commercial option
- The allowed amount should equal the sum of paid, deductible, and coinsurance amounts for both TPL and Medicare. The coinsurance amount will include copays.
- The Paid Date must be entered on the Coordination of Benefits screen when the claim is submitted as a secondary claim to MaineCare. Claims with no Paid Date will be denied.
- Click **Submit** to enter COB information.

- **Note:** When reopening the COB information, clicking **Cancel** from the COB Information window will delete all primary payment information previously entered. Clicking **Submit** will not delete this information.

***NOTE: Enter detail at the line level for more accurate claims processing.***

*If entering COB information, the **Paid Amt, Deductible Amt**, and **Coinsurance Amt** fields must be populated. If the paid, deductible, or coinsurance amount is $0.00, enter a "0" or "0.00" into the field. The online portal will not allow the manual entry of the "$" symbol when entering dollar amounts. Alternately, the provider may "tab through" the fields, and they will automatically populate with $0.00.*

*If there is no Medicare Action Code (MAC) on the EOB, leave this field blank. If a MAC is noted on the EOB, the code(s) must be entered.*

*When submitting the EOB for Medicare Part C, the user must write "Medicare" on the top of the EOB for accurate claims processing.*

*When reopening the COB information, clicking **Cancel** from the COB Information window will delete all primary payment information previously entered. Clicking **Submit** will not delete this information.*

## 4.2.5 Complete Oxygen Therapy Information

To enter Oxygen Service Information, click the **Enter Oxygen Therapy** link and then enter the information in the fields provided- see Figure 4-18 below.

- Click **Add** to add the information to the table.
- Edit the value by selecting the **Edit** icon;
- Modify the line as desired and click the **Save** button.

***NOTE:** The **Save** button appears when the Edit icon is selected.*

- Delete the value by clicking the **Delete** icon.

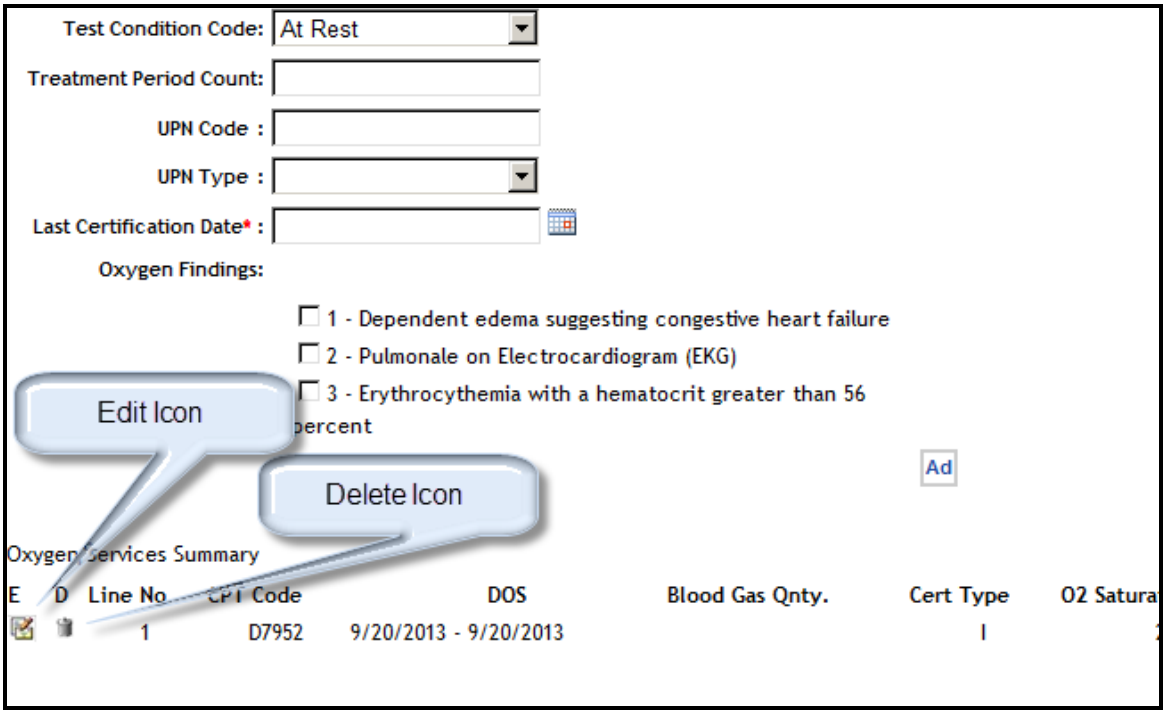


**Figure 4-18: Oxygen Therapy**

### 4.2.6 Complete the Additional Information Section

Complete the Additional Information section for the claim submission, shown in Figure 4-19 below, if applicable. The Additional Information section is used to enter information related to any third party liability associated with the claim.

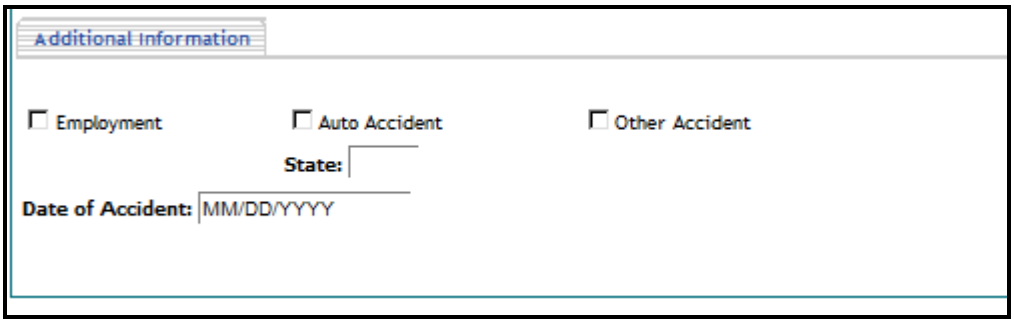


**Figure 4-19: Professional Additional Information Section**

If applicable, select the check box next to the correct type of accident associated with the claim: **Employment, Auto Accident,** or **Other Accident**. If the user selects a check box, enter the two-letter abbreviation of the state in which the accident took place.

Enter the date of the accident in eight-digit format (MM/DD/YYYY).

### 4.2.7 Submit the Claim

When all the claim information has been entered, click **Submit** to submit the claim. Any errors in the application will be indicated at the top of the page in red text and must be corrected before the claim can be submitted.

Upon the successful submission of the claim, a Claim Wizard Confirmation screen will populate.

## *4.3 Step 3 – The Claim Wizard Confirmation Screen*

Upon the successful submission of the claim, a Claim Wizard Confirmation screen will populate as seen in Figure 4-20 below.


**Figure 4-20: Claim Confirmation Screen**

**The Claim ID** is automatically displayed on the confirmation screen. The Claim Wizard Confirmation screen also presents the following options:

- **Claim View:** Used to view a summary of the information that was entered into the claim (claim summary).

- **Adjudicate Claim:** Processes the submitted claim against the business rules and readies it for finalization.
- **Edit Claim:** Used to **change** claim information.
- **Upload Attachment:** Used to **attach** any **additional** information that is required to support the claim submission. Uploaded documents must be uniquely named. Without a unique name, the document will not overwrite another document of the same name. The result is the original attachment will now be inappropriately attached to the current claim.
    - Claims with COB information must have a corresponding EOB attached. When submitting a Medicare Part C EOB, be sure to write "Medicare" on the top of the EOB.
    - Spenddown letters should be attached for each claim where the member has a coverage code of "Spenddown" for that particular date of service.

***NOTE:*** *Spenddown claims are entered via DDE according to the usual professional claim entry instructions in this guide in Section 4: Form Entry: Claim Submission.*

- **Print Attachment Cover Sheet**: Select to print a cover sheet for the attachment.
- **New Claim:** Used to create a new claim**.**

### 4.3.1 Claim View

Clicking the **Claim #** hyperlink reveals the original claim. Figure 4-21 below is an example of a claim view.

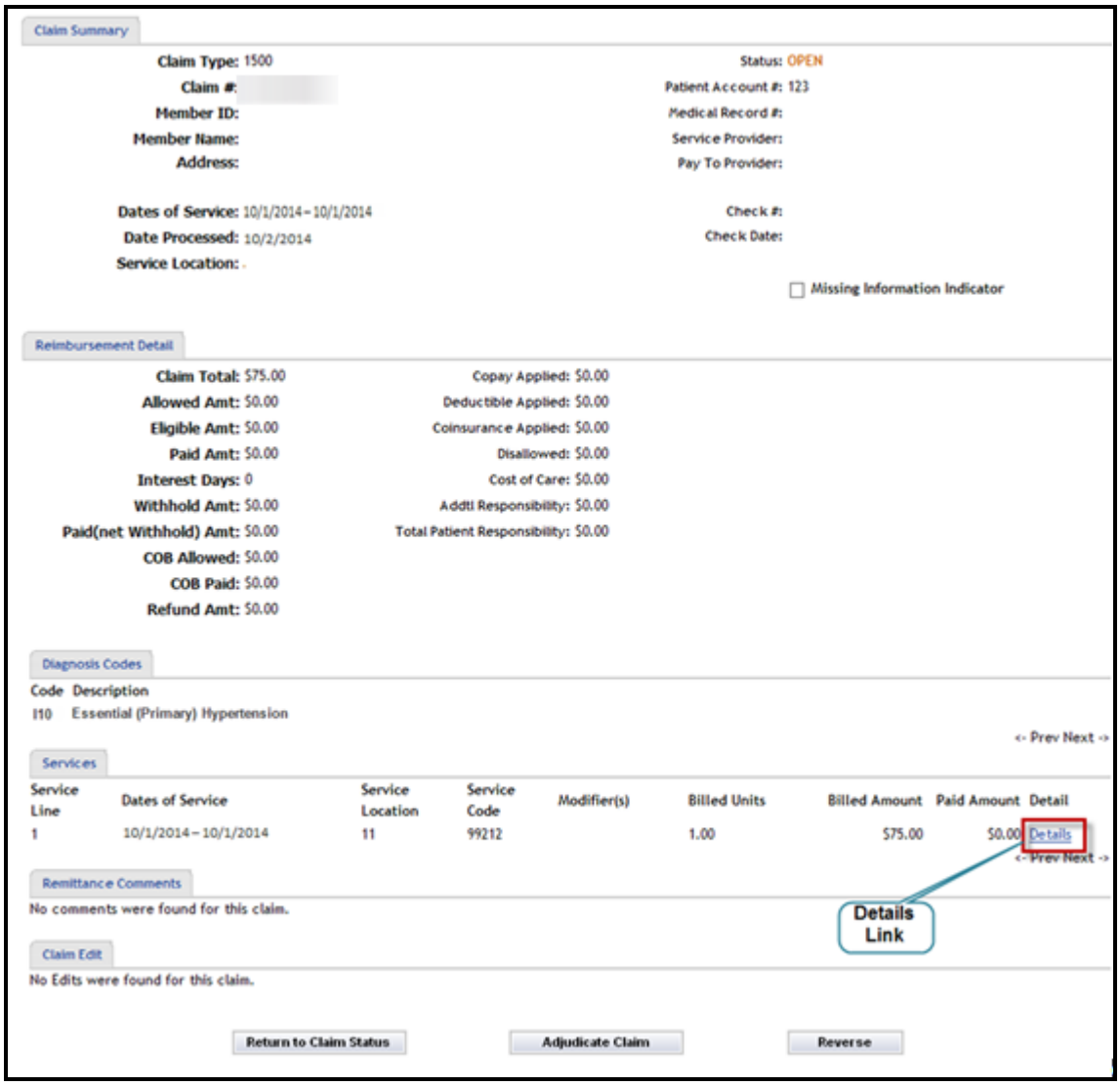


**Figure 4-21: Claim View**

View the details of a specific service line by clicking on the **Details** link at the end of that service line as shown above in Figure 4-21. An example of the service line detail is depicted in Figure 4-22 below.

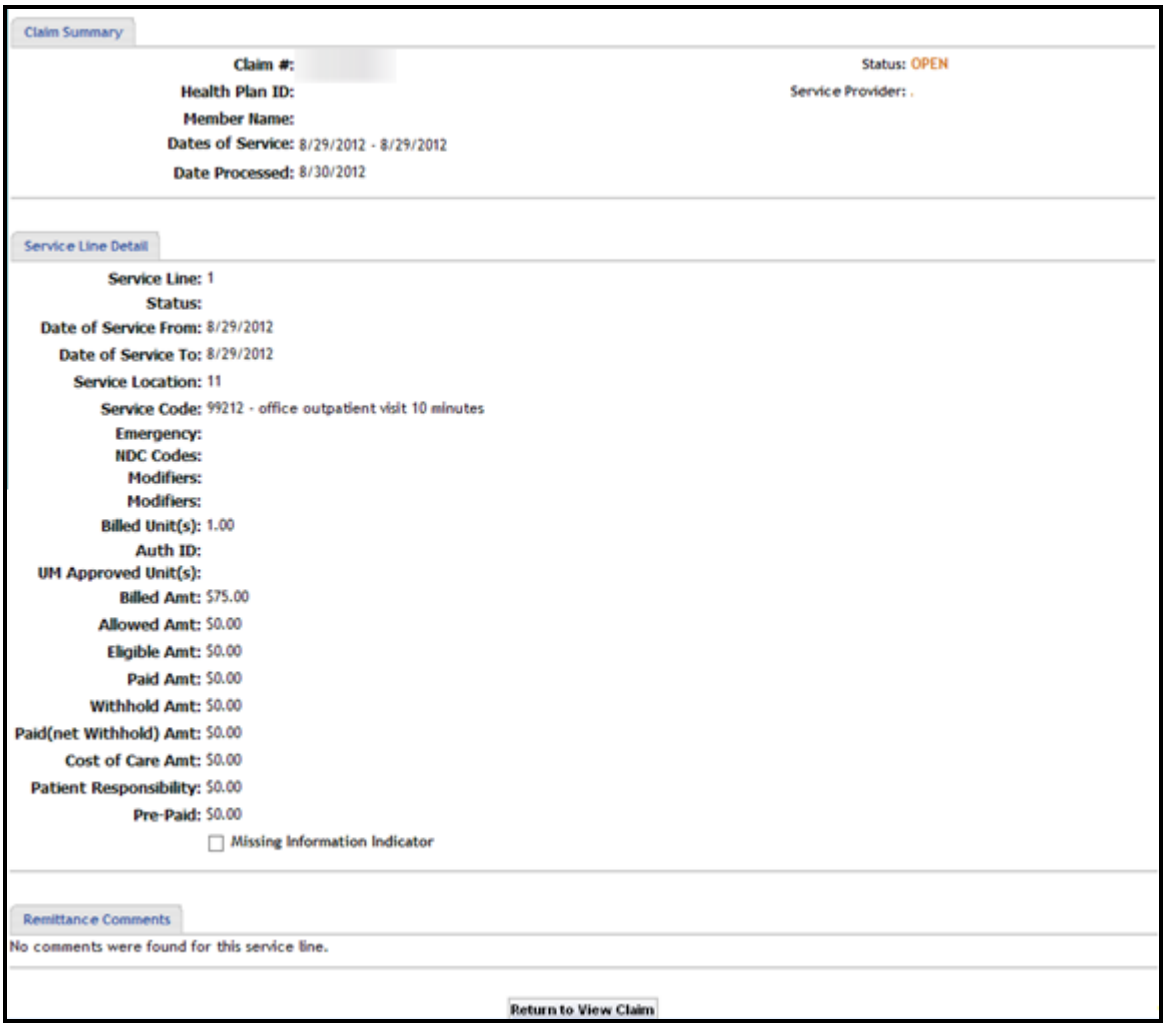


**Figure 4-22: Service Line Details**

After viewing the claim, the user may Adjudicate or Reverse it, Add Attachments, or Return to Claim Status by using the buttons at the bottom of the screen as shown in Figure 4-23 below.


**Figure 4-23: Claim Standard Buttons**

***NOTE:*** *A claim must be in a final (Paid) status before it can be reversed.*

## 4.3.2 Adjudicate Claim

The **Adjudicate Claim** button on the confirmation page initiates the claim adjudication process and sends the claim through predefined edits for real-time claims processing.

By viewing the status of the adjudication, the user can see if a claim has been successfully processed. If the claim fails to adjudicate, an error message will appear that reads, *"Warning: There are outstanding*

*edits"* as shown in Figure 4-24 below. The edits that caused the claim to fail adjudication will display under the Outstanding Edits header- see Table 3 below for a list of Claim Statuses.

A claim on the portal can be adjudicated up to 10 times. The message at the top of the screen reading "Number of online adjudication attempts: x" keeps a running count.

Claims may have edits posted that indicate if the edit is a warning, denial, or pend. **A warn edit does not prevent a claim from paying.**


**Figure 4-24: Adjudicate Claim**

After adjudication, the user may add attachments by selecting **Add Attachments**- see Figure 4-25 below.


**Figure 4-25: Add Attachments**

## 4.3.3 Edit Claim

Clicking the **Edit Claim** button opens the claim that was just submitted and offers the option to edit the claim and add or delete parts of the claim as needed before adjudicating the claim again.

Upon completion, three buttons offer further options: **Back, Save, Adjudicate**, as shown in Figure 4-26 below.

- Click **Back** to return to the screen before.
- Click **Save** to save any changes.
- Click **Adjudicate** to adjudicate the edited claim.


**Figure 4-26: Claim Back, Save, Adjudicate**

### 4.3.4 Upload Attachments

Attachments may be uploaded from the **Claims Status** window by clicking the **Add Attachments** button. A new window will appear as shown in Figure 4-27 below. For information on navigating to the Claim Status window, see Section 5: Claim Status.

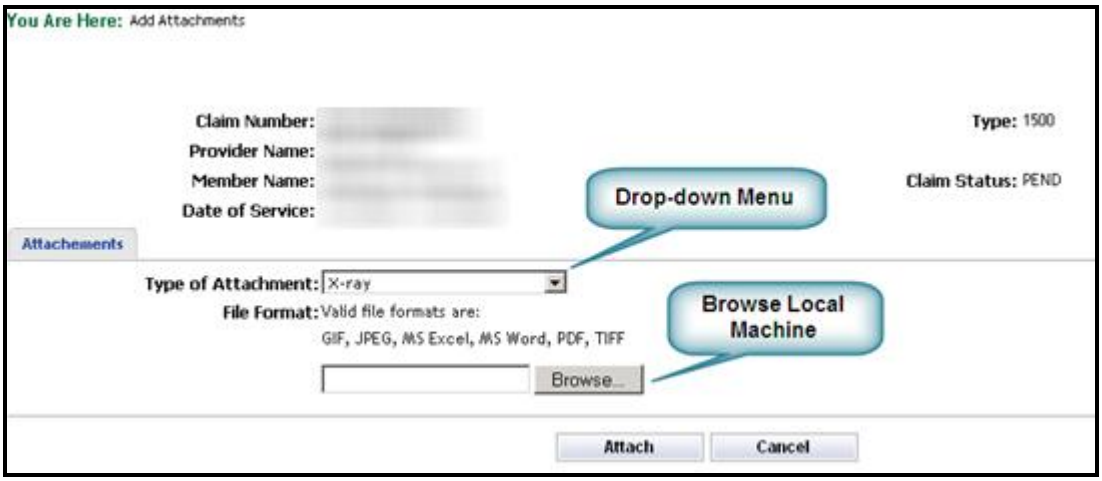


**Figure 4-27: Upload Attachments**

Claim information is pre-populated on the top of the page. To add an attachment, follow the steps below:

1. Click the drop-down menu to select the **Type of Attachment** that will be added.
2. Select the **Browse** button to locate the file on the local computer. All supporting document files must be in one of these formats: GIF, JPEG, MS Excel (.xls), MS Word (.doc), PDF, and TIFF.
3. Click the **Attach** button when the file to upload is listed in the **Browse** field.
4. Attachments may be uploaded through the portal for claims previously submitted via EDI or paper by searching for the matching claim in Claims Status and uploading a scanned attachment directly to the claim. See Section 5: Claim Status for more information on searching for claims by claim status. Attachments should be submitted on the same day. If appropriate attachment is not present when a claim is being reviewed, it will deny.
    - If the user is unable to upload required attachments, claims should then be submitted on paper with the appropriate attachment.

***NOTE*:** *If users are unable to upload electronic copies of attachments, fill out the **Cover Sheet for Claims** found on the Provider Page>Provider Documents>Forms>Claims. Be sure to include the **Claim number** provided on the confirmation screen. Send the cover sheet along with all mailed documents. If the appropriate attachment is not present when the claim is reviewed, the claim will deny*.

**Mail to:**

Claims Unit- Attachments
Office of MaineCare Services
11 State House Station
Augusta ME 04333-0011

# 5. Claim Status

To check the status of a claim, follow the steps below:

1. Select the **Claim Status** link under the **Form Entry** heading to access the claim status screen. See Figure 5-1 below.

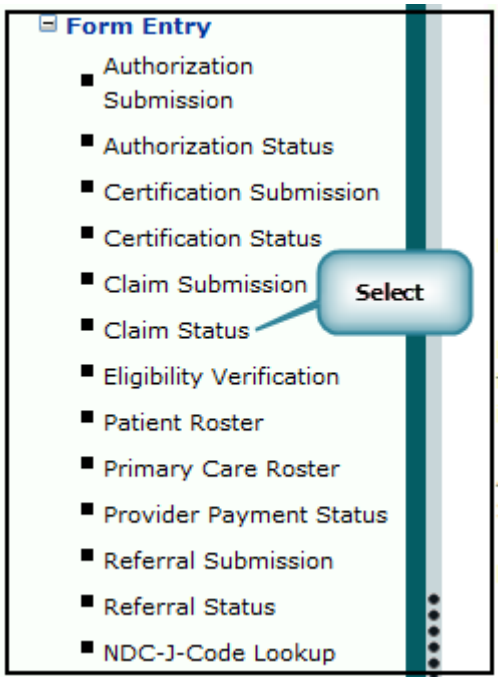


**Figure 5-1: Form Entry**

1. Select the proper provider from the **Billing Providers** drop-down menu. Claims associated with the selected Billing Provider will be displayed below the drop-down menu, under claim status- see Figure 5-2 below for reference.

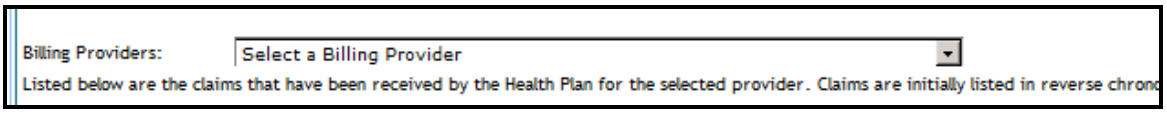


**Figure 5-2: Select Provider**

2. The search results for that Billing Provider are shown in the order of the newest to the oldest claims. Clicking on any underlined column heading will sort the lines according to the values in that column. To view claims in greater detail click the **Claim #** link as shown in Figure 5-3 below.


**Figure 5-3: Claim Status Screen**

3. Claim status identifies the processing stage of the claim. Table 3 below, groups the statuses into three categories: **Initial**, **Awaiting Payment**, and **Finalized**. Claims with an initial status of "Rev" or "Rev Synch" may not be edited. Claims with any other initial status may be edited by the provider. Claims in Finalized status of Paid may be Reversed or Replaced.

***NOTE:*** *If an attempt is made to Reverse or Replace a claim that is not Finalized, a standard error message will appear: "Cannot Reverse/Replace a Claim that is not Paid or Denied".*

See Table 3 below for more detailed explanations of the claims statuses.

**Table 3: Claim Statuses**

| **Claim Statuses** | |
|---|---|
| **Initial Claim Statuses** | |
| Open | The claim has been has been entered with the required fields for submission. |
| Adjudicated | The claim has been processed against the business rules of the system. |
| Deny | The claim has failed the adjudication process. |
| Pay | The claim has passed the adjudication process and is ready to be submitted for payment. |
| Pend | The claim has been set aside for review to determine if it should be paid or denied. |
| Rev | The claim is an inverse of a previously paid claim that is created to take away any payment error. |
| Rev Synch | The REV claim is held in this status until the companion replacement claim moves to Pay or Deny. |
| **Awaiting Payment Claim Statuses** | |
| Wait Deny | Awaiting the finalization of the claim denial for inclusion on the remittance advice. |
| Wait Pay | Awaiting the finalization of the claim payment submitted to AdvantageME for inclusion on the check and remittance advice. |
| Wait Rev | Awaiting the finalization of the claim reversal for inclusion on the check and remittance advice. |
| **Finalized Claim Statuses** | |
| Paid | The payment process is complete and is included in a Remittance Advice. |
| Denied | The claim has failed the adjudication process, has been denied and is included in a Remittance Advice. |
| Reversed | The negative claim has been finalized and is included in a Remittance Advice. |

| Claim Statuses | |
|---|---|
| Void | May be created as part of a mass adjustment (reversal and replacement) to void the replacement (adjustment) claim when only a reversal should have occurred. These transactions do not appear on a remittance advice or in an 835. They are administrative transactions only. |

4. Users can perform the following actions on selected claims: Edit, Adjudicate, Add Attachments, Reverse, Print Attachment Coversheet, or Print- see Figure 5-4 below.


**Figure 5-4: Claim Submission Standard Buttons**

## 5.1 View a Claim

To view a claim, see Section 4.3.1: Claim View above.

## 5.2 Search Claim

1. Click the icon as shown in Figure 5-3 above.
2. Searches may be performed on any of the fields available as shown in Figure 5-5 below.
   a. The dates entered in the **Date of Service From** and **To** fields must be fewer than 90 days apart.
   b. The **Search** button finds the claim(s).
   c. The **Reset** button clears all the values.
   d. The **Close** button closes the search area.

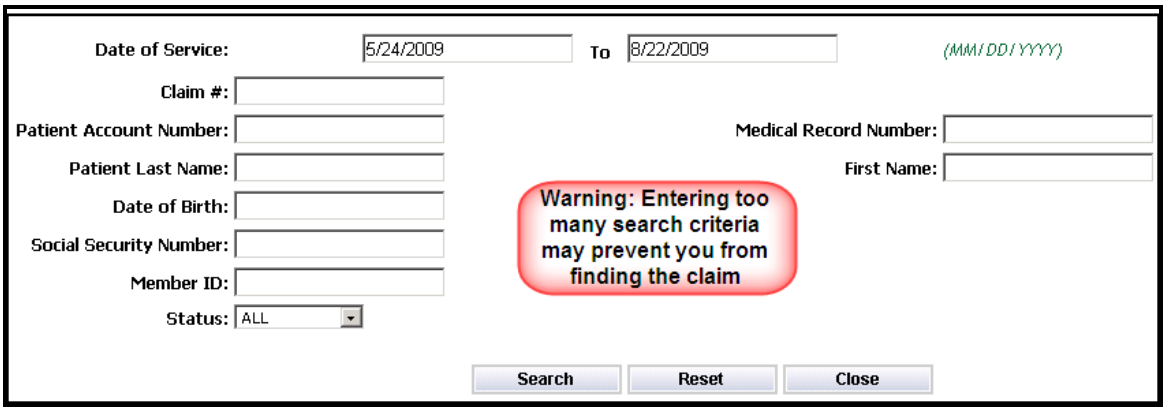


**Figure 5-5: Claim Search**

## 5.3 Edit Claim

Claims with an initial status of "Rev" or "Rev Synch" **may not be edited**. Claims with any other initial status may be edited. Refer to Table 3 above for the list of initial statuses. Claims with a finalized status of "Reversed" or "Void" cannot be reversed or replaced. "Denied" claims cannot be reversed and should be rebilled.

- Claims listed as "Open", "Adjudicated", "Pay", "Pend", "Rev", or "Deny" have not been finalized.
- Claims listed as "Paid", "Reversed", or "Denied" have been finalized (processed through the payment cycle).

Click the option button in front of the claim to select it for editing, as shown in Figure 5-6 below. Click **Edit** to edit the claim.

For additional information about editing a claim see Section 4.3.3 Edit Claim.

***NOTE:*** *If an attempt is made to Reverse or Replace a claim that is not Finalized, a standard error message will appear: "Cannot Reverse/Replace a Claim that is not Paid or Denied".*

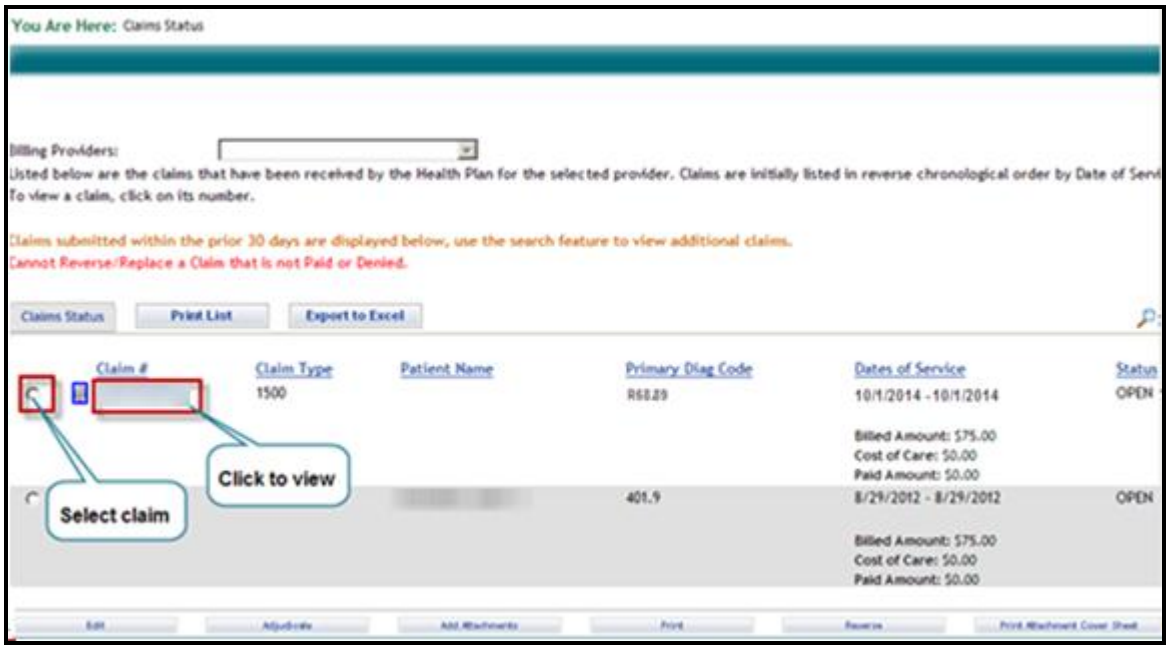


**Figure 5-6: Edit Claim**

Upon completion, three buttons offer further options: **Back, Save, Adjudicate**, as shown in Figure 5-7 below.

- Click **Back** to return to the screen before.
- Click **Save** to save any changes.
- Click **Adjudicate** to adjudicate the edited claim.


**Figure 5-7: Claim Edits Options**

## 5.4 Adjudicate Claim

To adjudicate a claim, see Section 4.3.2 Adjudicate Claim.

## 5.5 Reversing a Paid Claim

The user may reverse and replace any finalized paid claim. Users may also simply reverse the claim.

- A **Reverse** transaction reverses everything on the claim; the charged amount, payment and the units/visits are negated, etc.
- During the **Replace**, the claim data will be pre-populated. Users will have the option of changing the data prior to resubmission.

***NOTE:*** *When reopening the COB information, clicking* ***Cancel*** *from the COB Information window will delete all primary payment information previously entered. Clicking* ***Submit*** *will not delete this information.*

***NOTE:*** *When a reversal claim is submitted, and is in a status of "Rev" or "Rev Synch", the* ***Edit*** *and* ***Adjudicate*** *buttons at the bottom of the Claim Status screen will be greyed out.*

- The Original Claim, the Reversal Claim and/or the Replacement Claim will be visible in the system. This is for accounting purposes and will show on the next Remittance Advice.

To reverse and replace a claim, follow these steps:

1. Search for a claim by clicking the icon, as shown in Figure 5-3 above.
2. Select a claim.
3. Select **Reverse** on the claim status page, as shown in Figure 5-8 below.

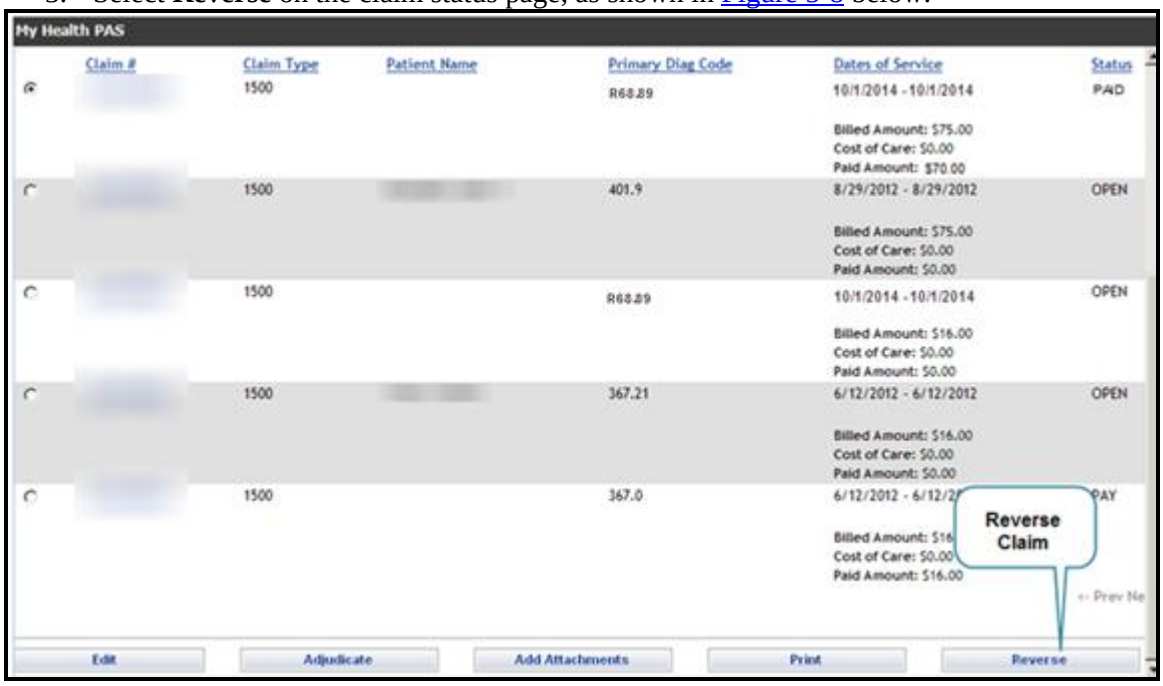


**Figure 5-8: Reverse a Claim**

4. On the next screen, select the option to **Reverse this claim and create a new claim.**

5. Preserve the existing data by checking the box next to **Use the data from this claim as basis for the new claim**, as shown in Figure 5-9 below. The new claim will have all applicable data copied over.

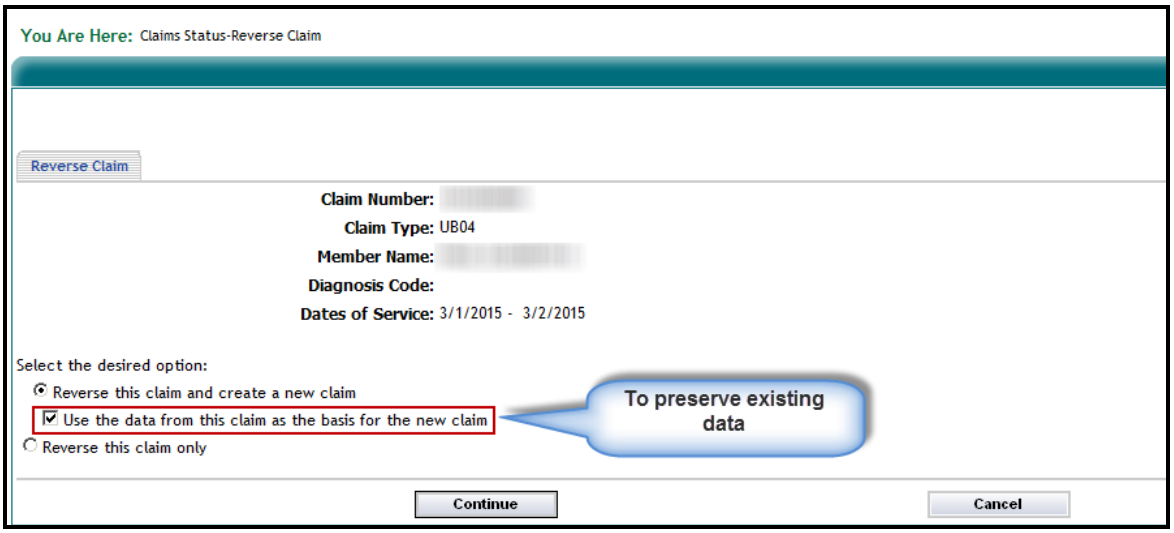


**Figure 5-9: Claim Status Reverse Claim**

6. Click OK when the verification question pops up, as shown in Figure 5-10 below.

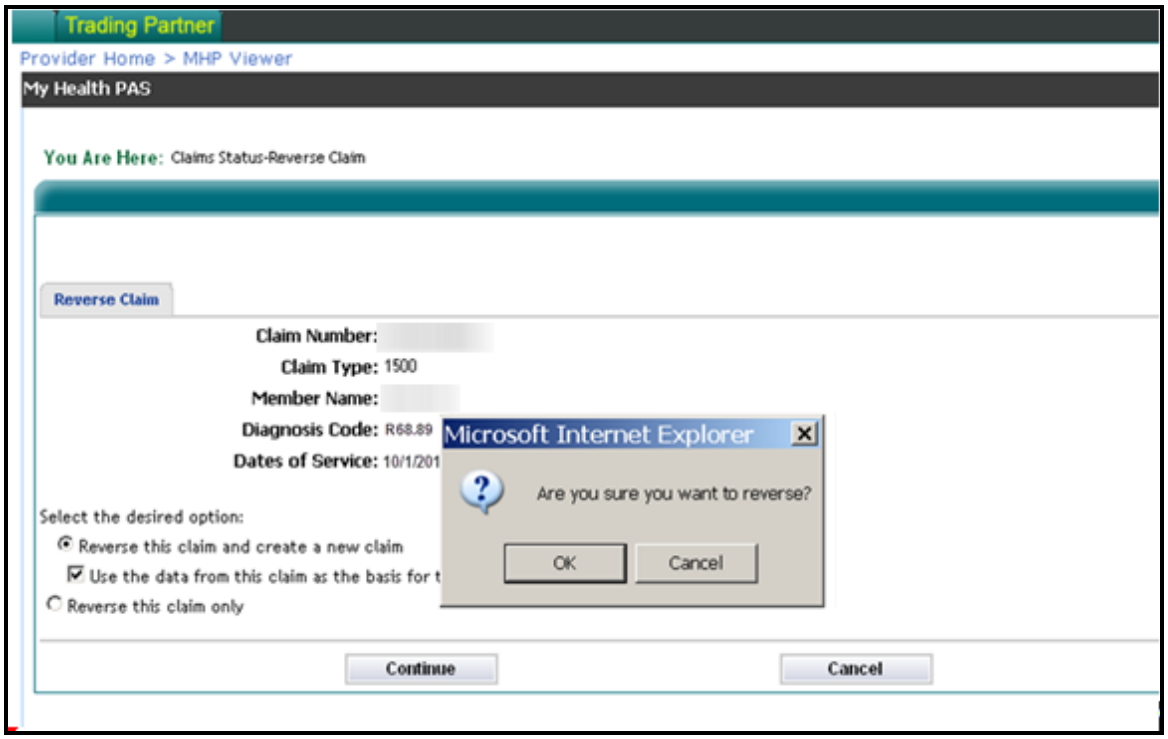


**Figure 5-10: Verification Question**

7. After the revisions are completed, the new claim can be submitted with the updated data.

***NOTE:*** *When a reversal claim is submitted, and is in a status of "Rev" or "Rev Synch", the* ***Edit*** *and* ***Adjudicate*** *buttons at the bottom of the Claim Status screen will be greyed out.*

- A **Reversed** Claim will have an R1 (or sequential number) at the end of the Claim number.
- A **Replaced** Claim will have an A1 (or sequential number) at the end of the Claim number.
    - The Replaced Claim will require a new Patient Account # since it is a new claim. Figure 5-11 below, provides an example of a successfully reversed and replaced claim.

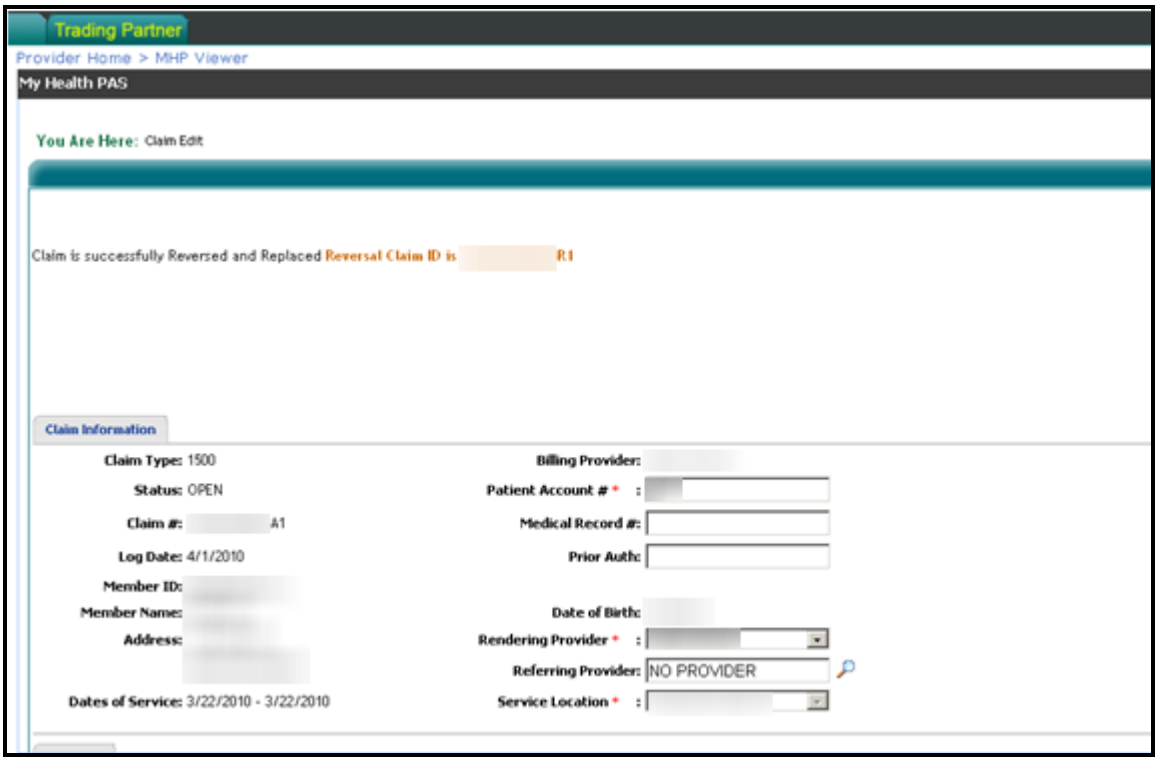


**Figure 5-11: Successfully Reversed and Replace Claim Screen**

Users may also choose **to reverse a claim without creating a replacement claim,** by selecting the **Reverse this Claim Only-** see Figure 5-12 below.

- A Reversal transaction reverses everything on the claim. The charged amount, the payment and the units/visits will be negated, etc.
- A Reversed Claim will have an R1 (or sequential number) at the end of the Claim number.

Figure 5-12 below provides an example of a successfully reversed claim.

***NOTE**: It is not necessary to click on **Continue** once users receive this reversal confirmation screen. Clicking on **Cancel** will bring the user back to the Claim Status page.*

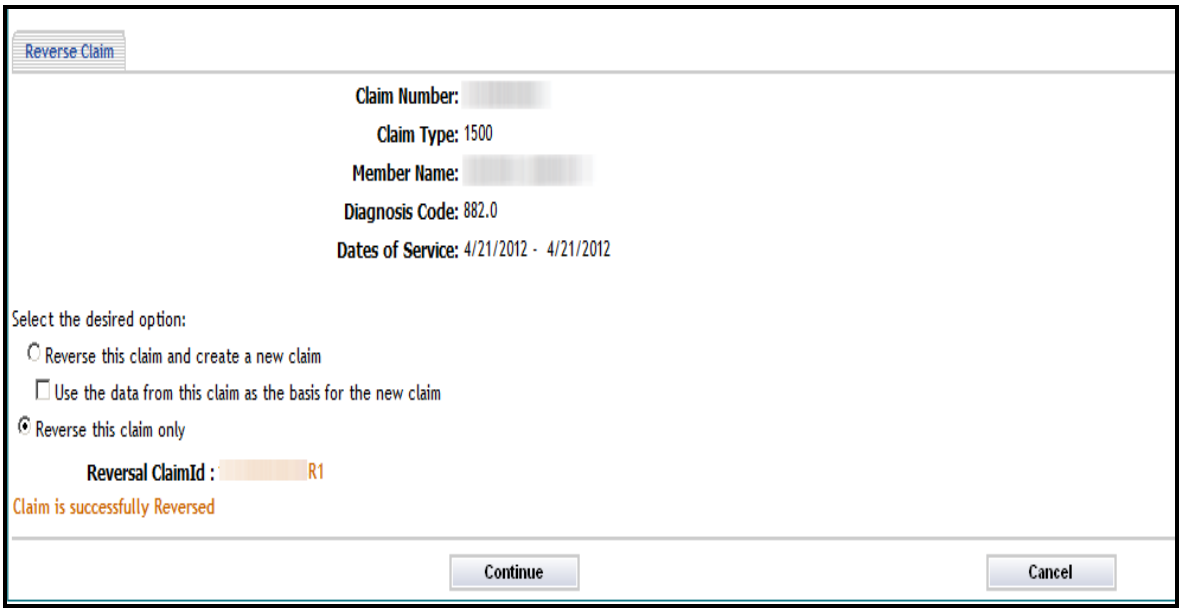


**Figure 5-12: Successfully Reversed Claim Screen**

# Appendix A. Place of Service Code List

**Table 4: Place of Service Code List**

| Code | Descriptor |
|---|---|
| 01 | Pharmacy |
| 03 | School |
| 04 | Homeless Shelter |
| 05 | Indian Health Service Free-standing Facility |
| 06 | Indian Health Service Provider-based Facility |
| 07 | Tribal 638 Free-standing Facility |
| 08 | Tribal 638 Provider Based Facility |
| 11 | Office |
| 12 | Home |
| 13 | Assisted Living Facility |
| 14 | Group Home |
| 15 | Mobile Unit |
| 17 | Walk-in Retail Health Clinic |
| 20 | Urgent Care Facility |
| 21 | Inpatient Hospital |
| 22<br>***NOTE**: Should be used when a provider qualifies as a "Provider Based" entity under 42CFR413.65.* | Outpatient Hospital |
| 23 | Emergency Room – Hospital |
| 24 | Ambulatory Surgical Center |
| 25 | Birthing Center |
| 31 | Skilled Nursing Facility |
| 32 | Nursing Facility |
| 33 | Custodial Care Facility |

| Code | Descriptor |
|---|---|
| 34 | Hospice |
| 41 | Ambulance – Land |
| 42 | Ambulance – Air or Water |
| 49 | Independent Clinic |
| 50 | Federally Qualified Health Center |
| 51 | Inpatient Psychiatric Facility |
| 52 | Psychiatric Facility – Partial Hospitalization |
| 53 | Community Mental Health Center |
| 54 | ICF/MR |
| 55 | Residential Substance Abuse Treatment Facility |
| 56 | Psychiatric Residential Treatment Facility |
| 57 | Non-Resident Substance Abuse Treatment Facility |
| 61 | Comprehensive Inpatient Rehabilitation Center |
| 62 | Comprehensive Outpatient Rehabilitation Center |
| 65 | End Stage Renal Disease Treatment Facility |
| 71 | State or Local Public Health Clinic |
| 72 | Rural Health Center |
| 81 | Independent Laboratory |
| 99 | Other |

# Appendix B. Transportation Origin/Destination Codes

Single letter modifiers must be combined to indicate the origin and destination for transportation services. These modifiers are entered in the Modifier(s) field of the Claim Service Section. A list of these destination and origin codes is provided in Table 5 below.

**Table 5: Transportation Origin/Destination Codes**

| Code | Description |
|---|---|
| D | Diagnostic or therapeutic site other than P or H |
| E | Residential domiciliary, custodial facility (nursing home, not skilled nursing facility) |
| G | Hospital-based dialysis facility (hospital or hospital-related) |
| H | Hospital |
| I | Site transfer (i.e.: airport or helicopter pad) between modes of ambulance transport |
| J | Non-hospital-based dialysis facility |
| N | Skilled Nursing Facility (SNF) |
| P | Physician's office (includes HMO non-hospital facility, clinic, etc.) |
| R | Residence |
| S | Scene of accident of acute event |
| X | (Destination code only) intermediate stop at physician's office enroute to the hospital (includes HMP non-hospital facility, clinic, etc.) |
| QL | Patient pronounced dead after ambulance called |
| UC | Unclassified ambulance service |

# Appendix C. NDC-J-Code Lookup

The MIHMS Health PAS Online Portal allows providers to query procedure code/NDC combinations and NDC rebate information by specific dates. The online portal will then display valid J-Codes and NDC combinations for MaineCare- see Figure 5-13 below. A list of the parameters required to perform an NDC-J-Code Lookup is provided in Table 6 below.

**DISCLAIMER:** The information used in this lookup is periodically updated; therefore, no guarantee of claim payment is expressed or given.

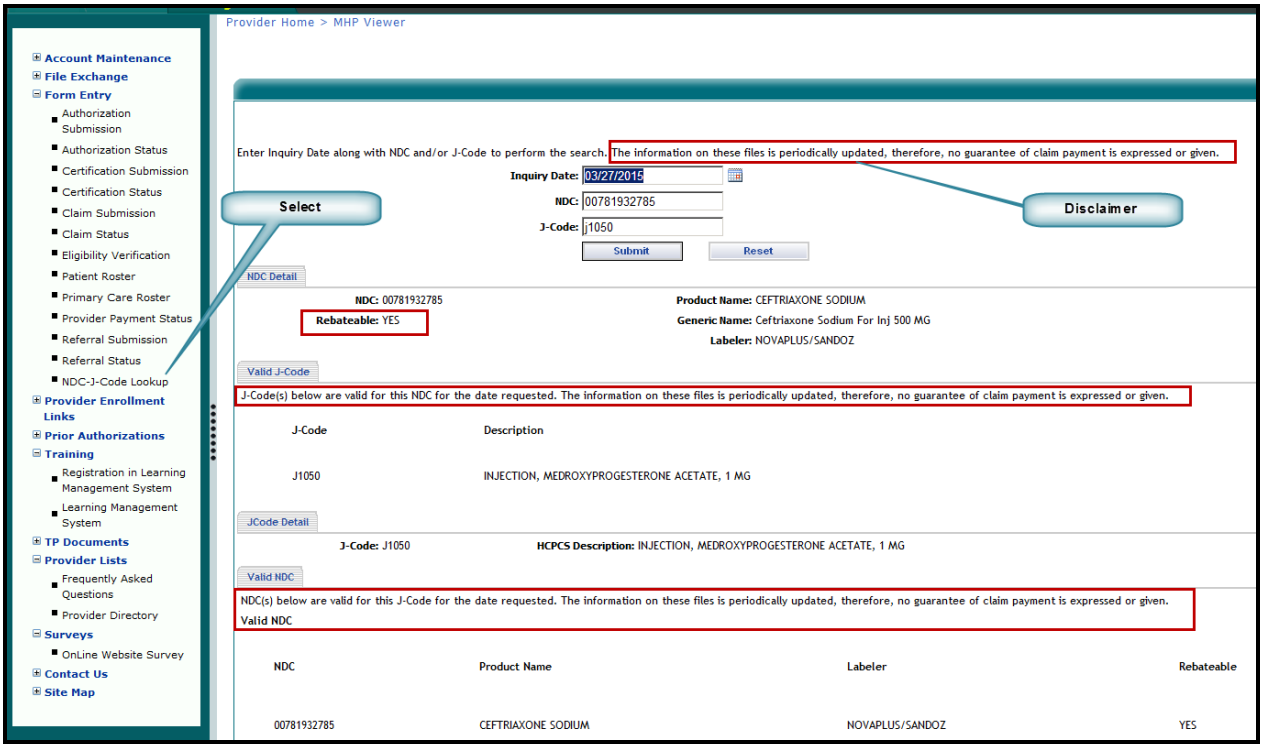


**Figure 5-13: NDC-J-Code Lookup**

**Table 6: NDC-J-Code Lookup Parameters**

| Field Name | Field Description |
|---|---|
| **Inquiry Date** | Enter the Inquiry Date to be used for validation of the information provided.<br>• **Dates must be entered in MM/DD/CCYY format. For example, February 14, 2015 would be entered as "02/14/2015":**<br>• **Cannot be a future date**<br>• **Can be selected with the calendar option**<br>• **Must be provided for valid combinations to be confirmed** |
| **NDC** | **Enter a valid 11 digit NDC Code**<br><br>***NOTE**: To see both the Product Name and the generic labeling enter only the NDC code.*<br>This tool uses multiple sources of data for validation: Medispan; CMS and Noridian which may cause differences in how the labelers name is displayed. In addition, the name of the NDC labeler could change and result in listing a different name. The intent of this tool is to confirm the validity of the J-code/NDC combination for a specific date. |
| **J-Codes** | **Enter a valid 5 character J-Code** |